1985
ANNUAL REPORT

ALBERTA
HEALTH FACILITIES
REVIEW
COMMITTEE

86-05227/

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Alberta

HEALTH FACILITIES REVIEW COMMITTEE

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14 April 1986

The Honourable David Russell,
Minister of Hospitals and Medical Care,
Room 420, Legislature Building,
Edmonton, Alberta.

Dear Mr. Russell:

I have the honour to present the Annual Report of the Alberta Health Facilities Review Committee, summarizing the activities of the Committee for the year ending 31 December 1985.

Respectfully submitted.

Dennis L. Anderson, M.L.A.
Chairman

1985
ANNUAL REPORT

of

THE ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

Submitted to

THE HONOURABLE D. J. RUSSELL
Minister of Hospitals and Medical Care

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OVERVIEW – 1985

In executing the Committee's mandate in 1985, members made routine, unannounced visits to 232 health care facilities and Senior Citizens' Lodges, received and investigated 75 complaints, and made recommendations to the Minister of Hospitals and Medical Care, the Minister of Housing, and to local Boards.

In addition, the Committee did a special study of the Senior Citizens' Lodge system in the Province. The study is included in this report.

The Committee has been very pleased with the response of the two Ministries and the local Boards to their recommendations, and with the co-operation of the Boards, administrators and staff of the facilities visited. We particularly appreciate the written response of the Minister of Hospitals to the observations and recommendations in the Annual Report.

DISCUSSIONS WERE HELD WITH THE FOLLOWING

The Honourable D. Russell,
Minister of Hospitals and Medical Care

The Honourable L. Shaben,
Minister of Housing

Senior Citizens' Homes Association

Alberta Hospital Association Nursing Home Committee

Interdepartmental Committee On Longterm Care

Mr. D. Junk, Assistant Deputy Minister,
Policy Development Division

Dr. D. Orn, Manager,
Longterm Care Program Section

Ms. Jean Schmidt,
Longterm Care Planner,
Social Services and Community Health

Nursing Home Standards and Review Team

Mrs. Evelyn Dragojevich, Manager
Ms. Beverly Jaap, Patient Care Consultant
Ms. Jane Thibaudeau, Dietician

ACKNOWLEDGEMENT

Mr. Bill Edgar and Mr. Brian Wik resigned during 1985, and the Committee wishes to express sincere appreciation for their valuable contribution during their years of service.

OBSERVATIONS

The Committee has been visiting health care facilities since 1974, and during that time has seen many improvements in Alberta's health care systems. Medical knowledge has expanded to include highly sophisticated methods of treatment and aspects of care have changed with increased knowledge of paediatrics, geriatrics, mental dysfunction and other illnesses. Our members have been impressed with the dedication of staff, administration and trustees.

As the system is good but not perfect, concerns have been received during the year, and the Committee has appreciated the assistance and co-operation of staff at all levels in finding solutions to the problems.

Following are the Committee's observations and suggestions.

PSYCHOGERIATRIC CARE

In the 1984 Annual Report, the Committee discussed the problems faced by nursing home and auxiliary hospital staff when mentally confused patients are cared for in the same ward as alert patients. The opinion was expressed that, while there did not appear to be a need to return to the concept of separate facilities specially designed for the care of mentally confused patients, the Committee believed there was a need for some type of separation within the nursing home system.

The Committee was pleased to note the announcement by the Government on 30 June 1985 that twelve 30-bed units for the care of psychogeriatric patients will be distributed throughout the Province. These units will be for the care of people with severe dementia and major behavioural problems and will provide some consultative backup to nursing homes and auxiliary hospitals. Although the number of patients who will be accommodated is relatively small (maximum 360), this is a positive step to ease the present situation in nursing homes and auxiliary hospitals.

However, when these units are in place it will still be necessary to place a number of confused patients in nursing homes and auxiliary hospitals, and the Committee feels that the special needs of patients with severe cognitive impairment would be better served in a separate area. Caring for such patients requires specialized nursing skills, and it would seem necessary for all staff to receive such special training if patients with severe behavioural problems are to be cared for in the general population of the nursing home or auxiliary. Providing a separate area with specialized nursing staff would not only provide high quality care, but would be more practical and cost efficient.

LEAVE OF ABSENCE FROM AUXILIARY HOSPITALS

The shortage of auxiliary hospital beds in Alberta poses a particular dilemma for patients and staff. Auxiliary patients admitted to a general hospital must return to the auxiliary within 48 hours or run the risk of losing their beds. The Committee realizes that there are people in the community waiting for auxiliary beds, but it is distressing for patients who have occupied a room in an auxiliary for months or perhaps even years, to find that, if they require treatment in an acute care hospital for more than two days, their possessions may be removed from their rooms and they will then have to be put on a waiting list until a vacancy occurs.

The Committee sympathizes with administration who have to balance the urgent need to fill an empty bed and the emotional need of the long-time patient to return to familiar surroundings, but would like to see consideration given to a policy change which would extend the period of leave for hospitalized residents.

COMPUTER COMFORT PROGRAM

At least four health care facilities in Alberta are involved in the Computer Comfort Program for severely disabled adults. The program was developed by the Neil Squire Foundation, a non-profit society, created to research and develop technical aids for the disabled. With this program it is possible, for example, for a quadriplegic (no use of either arms or legs) to learn to type. Staff analyze the needs of the individuals in order to provide suitable programs and appropriate adaptive devices. The computer can be run with a joy stick, an enlarged keyboard, a foot switch or even a straw-like device using only puffs of air in a Morse Code sequence to activate the system.

The disabled adult who evinces an interest in the program learns at his/her own pace, one on one, with a teacher who is a computer-wise university level student. The computer allows the disabled person to write, to have access to recreational, educational and vocational programs and to serve personal needs.

The computer is one key to greater independence, quality of life and freedom for the physically disabled individual.

INCIDENT REPORTS

It has been pointed out that incident reports are not considered part of a patient's medical record, but serve to advise Administration of the details of an accident or unusual occurrence so that action may be taken to prevent repetition. The Committee agrees with this definition but is of the opinion that there should be a notation on the patient's medical record indicating that an incident report has been completed and forwarded to Administration. There have been occasions when the Committee members visiting a facility in response to a complaint regarding patient care have reviewed incident reports and noted (a) reports not completed, and (b) no indication that the reports had been received by Administration. This kind of situation points to the need for improved incident documentation. Our Committee is aware that a new incident report form is at present being tested at selected facilities, and we hope that it will contain all pertinent information regarding unusual occurrences.

PERSONAL EMERGENCY RESPONSE SYSTEMS

Several facilities have recently installed Personal Emergency Response Systems. These systems enable a person with medical problems to remain in their own home and summon help in an emergency. A small device is worn and, when assistance is required, the wearer presses a button which activates a unit attached to the telephone. This is linked to a computer in a hospital or extended care facility, where trained personnel in the Emergency Response Centre are available twenty-four hours a day.

PHYSIOTHERAPISTS, OCCUPATIONAL THERAPISTS AND RECREATIONAL THERAPISTS

The revisions to Nursing Home Regulations have created an immediate demand for physio, occupational and recreational therapists. When this is added to the existing needs of hospitals, the shortage of qualified people in this field appears critical.

It is not felt that recruiting offshore therapists is a long-term solution, nor is it expected that Canada Employment and Immigration would permit this on an ongoing basis. It is therefore recommended by this Committee that the appropriate Government Departments taken action to expand the number of spaces available to Canadian students wishing to enter these professions.

FLOOR COVERINGS

Concerns have been expressed by administrators and staff about the extensive use of carpeting in prototypical hospitals and extended care facilities.

Sanitation is sometimes difficult to maintain in extended care facilities where there is a number of incontinent patients; in some facilities cleaning is an ongoing procedure and total shampooing is required at least once a month. Also, loaded food carts and wheelchairs are difficult to move over carpet.

If carpeting is proposed, careful consideration should be given to the type and to the areas where it is to be installed.

* SENIOR CITIZENS' LODGES

Programs and Activities:

Some excellent programs and activities were observed in some lodges throughout the Province in the past year. At one lodge, Access T.V. produced a film of the residents and their various activities. A grant was given to enable the co-ordinator and some residents to travel to other lodges to present their film. Residents are very pleased with the film, and proud of their lodge, and appear to be active and involved.

Matrons' Training Program:

Committee members were pleased to note the first Matrons' Training Program held in November 1985, sponsored jointly by the Department of Housing and the Senior Citizens' Homes Association. Matrons were pleased to have the opportunity to attend such a program. In past Annual Reports our Committee has recognized the need for this type of training to assist Matrons; we hope the programs will continue to be offered and all Matrons given the opportunity to attend.

Distribution of Medications in Senior Citizens' Lodges:

The Committee has been visiting Senior Citizens' Lodges since early 1974, and during that time concerns have been expressed by staff about dispensing and distributing medications. In 1974, a lodge might have had only one or two residents whose ability to be responsible for their own medications was in doubt. In the ensuing eleven years the average age of lodge residents has increased dramatically, and today, in some cases, staff dispense and distribute medications for two-thirds of the lodge's population. This has placed a great responsibility on lodge staff who do not have the training to provide this service.

When the Home Care Program was established, many lodges asked for and received assistance from the Home Care Nurse in setting up a Dosette system. The Dosette is a container that has a number of small compartments – four for each day in the week. The Home Care Nurse dispenses the medications for the week for each resident and a staff member is responsible for distribution. This system was an improvement and allayed to some extent the fears of staff. Often the family signed an agreement that, if a mistake in medications occurred, staff would not be held liable.

One problem of the Dosette system is that each compartment is separate but not enclosed and there is a possibility of spillage. Over the past year, a few lodges have requested assistance from local pharmacists in setting up a "bubble pack" system. Medications for each time of day are sealed in a compartment which is opened only when the medication is due. The local pharmacist makes up the pack for each individual requiring assistance and the staff distributes the medication. In those lodges, the pharmacist has given in-service training to staff so that all staff members are fully aware of the responsibility involved and feel more secure.

* This section is in addition to the Special Report recommendations to follow.

SENIOR CITIZENS' LODGE STUDY

In addition to its other work, the Committee established a sub-committee on lodges to look into the special problems which members were noting during their visits. The following paper is for discussion purposes, and represents the Committee's conclusions on the future of this part of the service to senior citizens.

A DISCUSSION PAPER

SENIOR CITIZENS' LODGES

ORIGINAL CONCEPT VERSUS PRESENT REALITY

A Report of
The Health Facilities
Review Committee

SUBCOMMITTEE OF LODGES

Chairman: Mollie Warring

Members: Dennis L. Anderson, M.L.A. (ex officio)
Ed Andersen
Brian Elliott
Brian Wik

"The Senior Citizens' Lodge – Original Concept versus Present Reality" report has been prepared by the Health Facilities Review Committee for discussion purposes. The Committee's objective in preparing this report is to inform the Government and the Alberta public about the present situation in lodges. It is hoped that the recommendations contained herein will assist both the Government and user groups in ensuring that our seniors are provided the best care possible, and that the existing facilities are most efficiently utilized.

INTRODUCTION

Since 1982, when the Health Facilities Review Committee conducted its last survey, statistics indicate that over 20% of Senior Citizens who live in lodges require additional nursing care beyond the parameters of the existing mandate, which is to provide only housing to Alberta seniors.*

Lodges, therefore, handle residents who require varying degrees of care for which lodge staff is not trained and for which a mandate does not exist.

The Home Care Program provides an excellent service to lodges; however, those residents requiring help continue to rely on lodge staff to provide care on an ongoing basis. Matrons and staff, for example, often assume the task of distributing medications, and assisting with personal hygiene which may involve lifting. Not only does this make them directly responsible for the residents' well-being, it may also place them in a vulnerable position whereby they could be held liable.

Many rural lodges currently have significant vacancies while nursing homes in the same communities are operating at full capacity and have waiting lists. Presently almost 1100 lodge beds remain empty, resulting in massive deficits each year to municipal governments who are responsible for operating the lodges through their respective Foundation Boards. (Alberta Housing Corporation 1982 and 1983 Deficit Reports.) This will be further indicated in the report.

This discussion paper identifies and reviews specific areas of concern, outlines some options and provides recommendations for a possible course of action.

HISTORY

Senior Citizens' housing was originally organized by the Provincial Government in 1958. Since the inception of the program, changes in policy and administration have taken place. Following is the historical background of the Senior Citizens' Lodge Program.

In August 1958 the Government proposed to build fifty Senior Citizens' Lodges in the Province over a five year period. In order to determine the amount of accommodation to be provided initially under the plan, the 1956 census figures were analyzed to ascertain the number of Senior Citizens in the Province and where they resided.

In 1959, the Legislation enacted the **Homes for the Aged Act** which provided that the community might enter into a Master Agreement with the Minister of Public Welfare (which subsequently changed its name to Department of Social Development) for the purposes of the construction and operation of Senior Citizens' Lodges. For administrative purposes, the Province was divided into fifty areas based on population, each having approximately five hundred persons aged seventy or over. Each administrative area was named a Foundation area which included one or more municipal districts, counties or improvement districts. Each city, town and village lying within the boundaries of the area had the option to become a contracting municipality of the Foundation.

Construction of the first homes began in 1959, and in 1960 thirty-two Senior Citizens' Lodges were completed and officially opened. By 1961, there were sixty-nine lodges operating in Alberta. In addition, the Province completed four hundred and eighty-four cottage-type units for elderly persons still able to do their own housekeeping and cooking. They were unfurnished, self-contained suites built adjacent to the lodges.

In 1970, Alberta Housing and Urban Renewal Corpora-

* The Foundation Charter states that the purpose of the lodges was "to provide low rental accommodation for elderly persons who are not suffering from any chronic disease or disability that incapacitates them to the extent of required specialized care; and the property of the Foundation shall be used only to provide such accommodation and recreational facilities and other services necessary or desirable for the physical and mental well-being of elderly persons."

tion became a crown corporation, subsequently changing its name to Alberta Housing Corporation, and took over the design, construction and financing of seniors' accommodation.

On April 1, 1971 the Senior Citizens' Lodge Program was officially transferred from the Department of Social Development to the Alberta Hospitals Services Commission. While applications for lodges were to be approved by the Commission, the design, construction and financing of the lodges remained the responsibility of Alberta Housing Corporation.

As Alberta Housing Corporation was also appointed to administer the subsidized housing and non-profit programs, there was increasing concern over duplication existing between the authorities providing accommodation for Senior Citizens, and the incompatibility of the Acts and policies of the main bodies involved i.e. The Alberta Hospital Services Commission and the Alberta Housing Corporation. There was a recommendation that the responsibility for the administration of **The Homes For The Aged Act** be transferred to the Minister of Municipal Affairs who was in charge of the Alberta Housing Act at that time.

In 1973, as a result of Bill 42, **The Senior Citizens' Housing Amendment Act**, the title **The Homes for the Aged Act** was struck and substituted by **The Senior Citizens' Housing Act**.

Furthermore, The Senior Citizens' Housing Act was assigned to the Minister charged with the administration of The Alberta Housing Act. Alberta Housing Corporation became the agency responsible for the approval of requests, design, construction and financing of the projects. At that time the financing policy had slightly changed. Instead of transferring the title of the lodge to the Foundation on completion of the project, Alberta Housing Corporation retained the title and leased to the Foundation for $1.00 ... in effect 100% Provincial Grant. The operating deficit was to be shared by the contracting municipalities.

CURRENT SITUATION

Information obtained from our 1985 survey of all lodges in the Province points to four areas of concern which are:

- the increasing average age of lodge residents
- the need for some form of health care in lodges
- the vacancy rate in lodges, and
- the pressure on nursing home beds in rural areas where lodge vacancy rates are highest.

These four factors may at first glance appear to be entirely separate or even conflicting, but they are in fact all inter-related.

The Health Facilities Review Committee believes the survey results provide a good understanding of the current situation.

A. INCREASING AVERAGE AGE

It has been established that the average age of residents is increasing. A survey by Alberta Housing Corporation in 1979 indicated that the average age was 80.6. Estimates by Foundation Boards in 1985 show the average ages ranging between 83 and 86.

According to the Bureau of Statistics, the longevity factor has increased by three years since 1971, with the projected life expectancy in 1986 of 80.1 for females and 73 for males. Since the Health Facilities Review Committee was established in November 1973, it has observed a dramatic increase in the average age of lodge residents.

The Alberta Population Projections Update 1984-2011, prepared by the Alberta Bureau of Statistics, shows that the Old Age Dependency ratio will be approximately 7.8% in 1986. By the year 2011, the Old Age Dependency ratio will increase to approximately 14.0%.

Of particular importance is the fact that while the

percentage figure almost doubles, the **actual** number of dependent Senior Citizens will **more** than double due to the real growth in population which will reach 3.65 million in Alberta. Add to that the increasing longevity factor, and almost every program and every facility in the Province may be outmoded, outdated or over extended.

In short, progressive changes need to be made now since requirements for the care of senior citizens will change drastically in twenty-five years.

B. HEALTH CARE

If the trend indicated in that survey continues, it is likely that the population of Senior Citizens' Lodges will require some form of health care. Deterioration in health due to age is already placing a higher demand on additional care within the lodge system. Statistics over the past few years indicate that over twenty percent of lodge residents require some form of assistance or depend on physical aids. (TABLE I)

C. VACANCIES IN LODGES

In some areas there is a high vacancy rate – eight percent in Edmonton and Calgary and fourteen percent in rural areas. (TABLE II)

A number of factors impact on lodge usage. The Senior Citizens' Self-Contained Housing Program makes independent living accessible by providing apartments at a rent of twenty-five percent of the eligible tenant's income; the Senior Citizens' Home Improvement Program provides assistance with home repair and renovation; the Home Care Program assists with nursing care and housekeeping; and Meals on Wheels provide nutritious food. Many people prefer the freedom of independent living and take advantage of these programs for as long as possible.

D. PRESSURE ON NURSING HOMES

The excellent programs currently provided by the Provincial Government for senior citizens in Alberta are invaluable in extending the time they can enjoy living independently. However, this may mean that, by the time people have to give up their homes, they require more care than can be provided by the present lodge system and lodge accommodation is left vacant while nursing homes become overburdened. (TABLE III)

TABLE I
1985 SURVEY

	Number of Residents	Assistance with Medications	Assistance with Bathing	Assessed for Nursing Home
CALGARY and EDMONTON	1268	77 (6%)	248 (20%)	57 (4%)
REST of PROVINCE	5837	1045 (18%)	1264 (22%)	256 (4%)

TABLE II

VACANCY RATE 1985	Number of Beds	Vacancies
CALGARY and EDMONTON	1383	115 (8%)
REST of PROVINCE	6782	945 (14%)

TABLE III

LODGE	VACANCIES	CLOSEST NURSING HOME	Percentage Occupancy of Nursing Home	* Number on Nursing Home Waiting List
ANDREW – Andrew Lodge	25	SMOKY LAKE – Smoky Lake Nursing Home TWO HILLS – Eagleview Nursing Home	100% 95% (1984)	15 55
BASSANO – Playfair Lodge	23	BROOKS – Brooks Nursing Home	100%	16
BOYLE – Wild Rose Villa	25	ATHABASCA – Extendicare Nursing Home	99.9%	7
COLD LAKE – Cold Lake Lodge	24	BONNYVILLE – Extendicare Nursing Home	100%	4
HIGH PRAIRIE – Pleasant View Lodge	31	HIGH PRAIRIE – J. B. Wood Nursing Home	80%	2
HYTHE – Hythe Pioneer Home	61	GRANDE PRAIRIE – Queen Elizabeth II Nursing Home GRANDE PRAIRIE – Central Park Lodge Nursing Home	95 - 100% 95%	22
MANNING – Del Air Lodge	21	PEACE RIVER – Sutherland Nursing Home	100%	0
MUNDARE – Father Filas Lodge	19	VEGREVILLE – Vegreville Nursing Home	100%	44
SEDGEWICK – Flagstaff Lodge	31	CAMROSE – Bethany Nursing Home	100%	43

* Figures were provided by each respective nursing home as requested by the Health Facilities Review Committee.

ALTERNATIVE PROGRAMS FOR USE IN LODGES

Respite Care, Day Care and Rehabilitation Programs, as well as shared homes are concepts worthy of attention. Increasing use of these programs may provide for the utilization of excess space in some lodges.

A. RESPITE CARE

One alternative now being implemented at Senior Citizens' Lodges where vacancies occur is Respite Care – a vacation relief program provided to families whose elderly live with them.

In June 1984, the Alberta Housing Corporation Board of Directors approved the Respite Care Program. The program has a number of positive aspects. It provides a service to seniors and their families in the community, and enables the Lodge Program to reach those who are in need of only occasional support rather than full-time care. This vacation relief service also gives lodges an opportunity to increase the use of vacant beds.

The following is an outline of the operational guidelines for the provision of vacation relief services in lodges.

- Vacation relief services may be provided through the utilization of existing vacant beds in lodges; but vacation relief residents must not displace any person wanting permanent lodge accommodation.
- The maximum number of beds allocated for vacation relief cannot exceed ten percent of the total bed capacity of the lodge.
- The maximum length of stay for any vacation relief resident is four weeks.
- Vacation relief residents should not place any additional personal care requirements on lodge staff. Rather, Home Care or other agencies in the community should provide the ancillary services.
- The maximum charge for vacation relief residents is $30.00 a day, but Foundations are allowed to charge a lower rate depending upon local circumstances.

Although no minimum rate has been set for this program, the Alberta Senior Citizens' Homes Association suggests that Foundations charge not less than $20.00 a day for vacation relief accommodation. Due to the additional costs involved as a result of high turnovers, it is not unreasonable to charge temporary residents a rate which is higher than that of normal room rates. At present, our research shows that the Greater Edmonton Foundation and Westview Lodge at Rocky Mountain House provide the option of Respite Care.

B. DAY CARE AND REHABILITATION

In both rural and urban areas of this Province, there are increasing numbers of residents in the lodge system who require basic care, which would assist individuals to care for themselves and live with dignity. Therefore there may be a need for lodges to examine participation in the Day Care Program.

Day Care "provides an organized social program for the frail, moderately handicapped or slightly confused older person, or handicapped person who requires some care and supervision for the day and for some part of the week, either because he/she is lonely and isolated, or to provide relief for the care giver.

"The Day Care (Program) should provide a pleasant and safe environment, including socialization, activities, rest periods and a nutritious meal. The activities should aim to promote socialization, mental stimulation and physical wellbeing." Such a program can serve not only the residents of a lodge, but also those in the community wishing to stay at home. The objective of a Day Care Program is not to turn lodges into mini-medical facilities, but to provide additional care which will maintain present level of functioning, allowing the individual to remain for a longer time in a lodge or in their home. It would provide, in some cases, a form of rehabilitation.

The construction, function and location of lodges make them suitable for the provision of Day Care Programs. Access to the community is good; in most lodges there are rooms available for activities and programs; where there are vacancies beds can be made available

for rest periods; and ongoing meal services to lodge residents would provide access to nutritious meals.

Co-ordinating Day Care Programs in both rural and urban settings could be achieved with the help of existing organizations; Home Care or Social Services and Community Health could call upon their area co-ordinators and staff to develop programs and other professional and community groups could participate. This would not eliminate the use of volunteers who would be very necessary to such programs.

It goes without saying that there could be some obstacles to placing Day Care Programs in lodges. It is a move away from the original concept that a lodge is a home not a care-giving centre; in some instances, the lack of proper space could make such a program difficult to arrange; and, in some centres, there might not be enough professional help or back-up services to have the program run smoothly.

However, a Day Care Program brings with it many advantages. With the establishment and continuance of such a program, the result will be healthier people better able to take care of themselves; and socialization will provide mental stimulation. There will be greater utilization of a lodge, its space, and its role in a community. Individuals enjoying the program may seek to take up residence in the lodge, further increasing occupancy. In addition a lodge may be seen as a place to go to improve one's health, rather than the first of a series of steps to complete care.

C. SHARED HOMES FOR SENIOR CITIZENS

A new concept being seriously investigated by the Lutheran Welfare Society of Alberta in Calgary, is the development of a Shared Home Program for senior citizens which would house approximately ten people in each housing unit. The home would provide private bedrooms and bathrooms for the residents, and shared amenities such as kitchen and lounge areas. Each home would employ a house mother, with the overall management and administration the responsibility of the Lutheran Welfare Society.

If approvals of this concept are soon forthcoming, construction of the first shared home could start as early as January 1986.

The Shared Housing Programs are currently operating successfully in several American States. This is a future possibility in dealing with the needs of our aging population.

SINGLE POINT OF ENTRY

Some lodges in rural areas have entered into a type of health care, whether through natural progression or because of inadequate nursing home/auxiliary care facilities. The three Departments, (Hospitals and Med.i.cal Care, Social Services and Community Health and Housing), and the Alberta Mortgage and Housing Corporation, believe that a co-ordinated assessment and placement service for long term care in Alberta is essential. The Single Point Entry System is an integrated assessment procedure for care services, where one assessment is undertaken to determine whether a client requires services from a community-based Home Care Program, or requires placement in a Senior Citizens' Lodge, a nursing home or an auxiliary hospital.

A Single Point Entry Assessment would encompass a body of representatives from all community support services. This would reduce jurisdictional problems and ensure the proper placement of individuals within the system. Senior Citizens' Lodges and self-contained housing units would form an integral part of the system.

Currently there does not appear to be an assessment system for Senior Citizens entering the lodge housing program, or for those now living in lodges. Some Foundations may be reluctant to recommend or request the reassessment of a resident, either because of a high vacancy rate or the lack of other available facilities in the area. This could deprive the resident of the required care, and constitute a disservice to him/her as well as to the employees and other residents of the lodge.

The Senior Citizens' Homes Association has in the past supported the concept of a central assessment body and single point of entry to care for seniors, provided the local Foundation has final authority on the occupancy of its facilities. This proviso does not appear to be a concern as long as each Foundation is part of the regional assessment team. It would appear from the studies and models completed by various Departments and interested parties, that Single Point of Entry and Assessment warrants serious consideration. A method of implementation satisfactory to all levels of care should be reached as soon as possible. The Health Facilities Reveiw Committee feels that this program will help ensure that our system is properly utilized. Single Point of Entry projects are currently underway in Black Diamond, High River and Nanton.

RECOMMENDATIONS ON UTILIZING VACANT LODGE BEDS

The following are observations the Committee considered in reaching its conclusions on how best to provide for the nursing care needs of Senior Citizens living in lodges.

CURRENT SITUTATION

While the vacancy rate in rural lodges has been established, there is a serious shortage of nursing home beds in these same communities. It follows that, where additional nursing bed facilities are required, vacant beds in lodges could be converted to some nursing care. This would answer a public need, as well as utilizing unproductive space.

Members of the Health Facilities Review Committee surveyed a number of Senior Citizens to determine their views on reclassifying some lodge beds as nursing care beds and the response was generally favourable. General comments were that, should their health begin to fail, they would prefer to remain in the lodge instead of going to a nursing home. Others stated they would be pleased to assist their neighbours in the event of frail health rather than see them leave the lodge to go to a nursing home. Thus this recommendation on utilizing vacant lodge beds is not only economic but also humanitarian.

In those lodges that require change, the economic factors of physically converting the facilities and the additional funding required to integrate nursing care personnel with existing staff must be further evaluated. The Health Facilities Review Committee is of the firm opinion that physically converting vacant lodge beds to intermediate nursing care beds will not, in most cases, be required. The major cost factor will be in upgrading staff by adding required nursing care personnel. This would vary from lodge to lodge. In some cases only minor upgrading would be required and in others no upgrading would be necessary, depending on the assessed need.

UPGRADE THE HOME CARE PROGRAM AND LEAVE LODGES UNDER THE PURVIEW OF THE DEPARTMENT OF HOUSING

Another recommendation is to greatly expand the Home Care Program to provide more services to lodge residents.

The Home Care Program was expanded recently and has been very effective in providing necessary care to many residents of lodges. But, as the Home Care Program has grown, residents have become older and more and more are likely to require expanded nursing care, rehabilitation, and personal care services. This has major implications for services to lodge residents.

We have seen a marked increase in the Home Care case load. The active case load for lodge residents for

the month of November 1983 was:

(a) Admissions	66
(b) Discharges	67
(c) Active Case Load	1087

and for the month of November 1984:

(a) Admissions	90
(b) Discharges	55
(c) Active Case Load	1264

This represents 36% increase in admissions, 17.9% decrease in discharges and a 16.3% increase in the active case load. Lodge residents accounted for 14.2% of Home Care's client case load for the month of November 1984.

Home Care will continue to be an active and important part of the health care of lodge residents but, as the needs of residents continue to increase, a possible restructuring of Home Care may be required to provide a 24-hour a day service.

FORMAL RECOMMENDATIONS

The Health Facilities Review Committee recommends the following:

1. That each lodge be assessed by a team consisting of representatives of the Departments of Hospitals and Medical Care, Housing and Social Services and Community Health, with the input of the local community, which should include the Foundation Board, Senior Citizens' Homes Association, Council on Aging, and the Health Facilities Review Committee, to determine the following:

   (a) If the individual lodge is best serving the needs of its residents and community;

   (b) If nursing care is required in the lodge;

   (c) The utilization, where practical, of programs such as Respite Care, Day Care, Rehabilitation or others.

2. That the Assessment Team place great emphasis on evaluating the specific needs of the individual resident.

3. That a funding formula be developed by the Department of Housing in co-operation with the Department of Hospitals and Medical Care to facilitate required assessed changes in lodges.

CONCLUSION

The increasing health care needs of residents, and the fact that the rural lodges are currently under-utilized while nursing homes in those areas are at full capacity, were the principal factors in the recommendations of this report.

Allowing some lodges to provide nursing care would be economically helpful to Foundation Boards; special funding for programs like Respite Care and Day Care for other lodges with high vacancy rates might also assist in decreasing deficits.

Another beneficiary would be the taxpayer. Albertans would receive maximum use of beds in lodges, and the need for more nursing home beds would be reduced.

The Health Facilities Review Committee wishes to state clearly that it is not recommending that lodges be converted to nursing homes. It does, however, feel strongly that nursing care to lodge residents, where need is assessed, must be appropriately provided.

The Committee is aware that residents do not want to be institutionalized and any change from the original concept must recognize this very positive aspect of the lodge program. We believe that nursing care, where necessary, can be provided without jeopardizing the feeling of home and community that has been established in Alberta lodges.

It is the Committee's conclusion that statistics presented in this report clearly indicate that the original mandate of lodges is no longer in operational practice, and it is essential to address the realities prevalent today.

The Senior Citizens' Lodge mandate should be revised accordingly.

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APPENDIX I

HISTORY OF THE COMMITTEE

The Alberta Hospital Visitors Committee was established by the Alberta Hospital Visitors Committee Act in 1972, with a mandate to visit and inspect health facilities throughout the Province. Institutions included were Active Treatment Hospitals, Auxiliary Hospitals, Nursing Homes, Mental Health Facilities, and Homes for Special Care. The Act was amended in 1973 to include Senior Citizens Lodges and Contract Nursing Homes. The first meeting of the Committee took place in November 1973, and the first visits in March 1974.

An amendment in November 1978 changed the name to the Alberta Health FAcilities Review Committee, and clarified the Committee's authority to receive and investigate complaints. The investigation of complaints had always been part of the Committee's role, but it was felt that it should be clearly stated that the Committee's mandate included the investigation of complaints in private nursing homes.

Social Services and Community Health institutions, and Mental Health Hospitals, were removed from the Committee's mandate, and the Social Care Facilities Review Committee was established to undertake this responsibility. Subsequently, in 1983, the two Mental Health Hospitals were returned to the mandate of the Health Facilities Review Committee.

The revised Alberta Health Facilities Review Committee Act was proclaimed in August 1980. The Act provides broad terms of reference for the Committee's activities, excluding only access to individual treatment records and financial records of the institution.

APPENDIX II

ACTIVITIES

REGULAR MEETINGS

Meetings of the Committee are held regularly, usually at monthly intervals. The Committee's schedule for the forthcoming month is approved, reports are presented on institutions visited, and the status of complaints under investigation is reviewed.

Eleven regular meetings and one special meeting were held during 1985.

CONVENTIONS

Mr. Brian Elliott and Mr. Brian Wik attended the Senior Citizens' Homes Association and Mrs. Betty Biddell and Mrs. Colleen Wood attended the Alberta Hospital Association Convention in November 1985.

ROUTINE VISITS TO INSTITUTIONS

Routine visits to institutions are planned monthly, and are authorized by resolution of the Committee. A visiting team is usually made up of two to four members. Time spent at each institution on such visits may be up to three days, depending on the size of the institution. Visits are unannounced.

The visiting team reports on care, atmosphere, comfort, food, activities and programs, community involvement, patient/guest morale, staff morale and general attitudes, and physical plant. After meeting with the administration and being shown through the building, members conduct the visit unaccompanied by staff. Discussions with patients, staff and visitors are, as often as possible, on a one-to-one basis. The Committee sees its role as that of considering the institution from a patient's/resident's point of view.

The visiting members prepare a written report on the institution for the Committee's records and the findings of the visit are discussed by the Committee at the next regular meeting. When concerns are expressed or favourable comments made to the visiting members, they are brought to the attention of the facility's administration and/or Board and in some cases the appropriate Government Minister, by letter or verbally. Where necessary the Committee schedules a follow-up visit.

The following institutions were visited in 1985. (Additional visits were made to investigate complaints).

GENERAL HOSPITALS (71)

Athabasca Municipal Hospital
Banff – Mineral Springs General Hospital
Barrhead General Hospital
Bashaw General Hospital
Bassano General Hospital
Bentley General Hospital
Black Diamond – Oilfields General Hospital
Bonnyville – St. Louis General Hospital
Bow Island General Hospital
Boyle General Hospital
Breton General Hospital
Calgary – Foothills General Hospital
Calgary General Hospital
Camrose – St. Mary's General Hospital
Canmore Municipal Hospital
Cardston Municipal Hospital
Cereal Municipal Hospital
Coaldale Community General Hospital
Cold Lake – John Neil General Hospital
Daysland General Hospital
Didsbury Municipal Hospital
Drayton Valley Health Care Complex
Drumheller General Hospital
Edmonton – Charles Camsell Hospital
Edmonton General Hospital
Edmonton – Glenrose Provincial General Hospital
Edmonton – Misericordia Hospital
Edmonton – Royal Alexandra Hospital
Edmonton – Dr. W. W. Cross Cancer Institute
Edson – St. John's Health Care Complex
Empress Municipal Hospital
Fort Macleod Municipal Hospital
Fort Saskatchewan General Hospital
Galahad General Hospital
Glendon Municipal Hospital
Grimshaw – Grimshaw-Berwyn and District General Hospital
Hanna General Hospital
Hardisty General Hospital
High Prairie Regional Health Care Complex
High River General Hospital
Innisfail Health Care Centre
Islay Municipal Hospital
Killam General Hospital
Lacombe General Hospital
Lamont – Archer Memorial Hospital
Leduc Municipal Hospital
Lethbridge – St. Michael's General Hospital
Magrath Municipal Hospital
Manning Municipal Hospital
Mannville Municipal Hospital
Mayerthorpe General Hospital
Medicine Hat General Hospital
Mundare – Mary Immaculate General Hospital
Myrnam Municipal Hospital
Oyen – Big Country General Hospital
Peace River Municipal Hospital
Pincher Creek Health Care Centre
Ponoka General Hospital
Provost Municipal Hospital
Redwater – Thorhild County General Hospital
Rimbey General Hospital
Slave Lake General Hospital
Stettler General Hospital
Taber General Hospital
Tofield Municipal Hospital
Two Hills Municipal Hospital
Valleyview General Hospital
Viking Municipal Hospital
Vulcan Municipal Hospital
Wetaskiwin General Hospital
Whitecourt General Hospital

AUXILIARY HOSPITALS (21)

Calgary – Glenmore Park Auxiliary Hospital
Camrose – Bethany Auxiliary Hospital
Cardston Auxiliary Hospital
Didsbury – Mountain View-Kneehill Auxiliary Hospital
Drumheller – J. Cramer Auxiliary Hospital
Edmonton – Allen Gray Auxiliary Hospital
Edmonton – Good Samaritan Auxiliary Hospital
Edmonton – Grandview Auxiliary Hospital
Edmonton – Millwoods Shepherds' Care Centre
Edmonton – Norwood Auxiliary Hospital
Edmonton – St. Joseph's Auxiliary Hospital
Edmonton – University of Alberta – Aberhart Wing
Killam – Flagstaff Auxiliary Hospital
Lamont Auxiliary Hospital
Lloydminster Auxiliary Hospital
Medicine Hat – Dr. Dan McCharles Auxiliary Hospital
Peace River-Fairview Auxiliary Hospital
Rimbey Auxiliary Hospital
Stettler – Dr. A. E. Kennedy Auxiliary Hospital
Wainwright Auxiliary Hospital
Wetaskiwin Auxiliary Hospital

NURSING HOMES (54)

Athabasca – Extendicare Nursing Home
Barrhead Nursing Home
Bonnyville – Extendicare Nursing Home
Calgary – Beverly Nursing Home
Calgary – Bow View Nursing Home
Calgary – Brentwood Nursing Home
Calgary – Cedars Villa Nursing Home
Calgary – Chinook Nursing Home
Calgary – Forest Grove Nursing Home
Calgary – George Boyack Nursing Home
Calgary – Glamorgan Nursing Home
Calgary – Mayfair Nursing Home
Calgary – Scottish Nursing Home
Calgary – Southwood Nursing Home
Camrose – Bethany Nursing Home
Cardston – Grandview Nursing Home
Didsbury – Mountain View-Kneehill Nursing Home
Drumheller – Dr. T. R. Ross Memorial Nursing Home
Edmonton – Dr. Angus McGugan Nursing Home
Edmonton – Central Park Lodge (Lendrum) Nursing Home
Edmonton – Extendicare (North) Nursing Home
Edmonton – Extendicare (Southgate) Nursing Home
Edmonton – Good Samaritan Nursing Home (Mount Pleasant)
Edmonton – Good Samaritan Nursing Home (Southgate)
Edmonton – Hardisty Nursing Home
Edmonton – Jasper Place Central Park Lodge Nursing Home
Edmonton – Jubilee Lodge Nursing Home
Edmonton – Millwoods Shepherd's Care Nursing Home
Edmonton – St. Michael's Nursing Home
Edmonton – Venta Nursing Home
Edson Nursing Home
Fort Macleod – Extendicare Nursing Home
Fort Saskatchewan – Rivercrest Lodge Nursing Home
Hanna – Palliser Nursing Home
High Prairie – J. B. Wood Nursing Home
High River Nursing Home
Lacombe Nursing Home
Lamont Nursing Home
Leduc – Extendicare Nursing Home
Leduc – Salem Manor Nursing Home
Lethbridge – Edith Cavell Nursing Home
Lethbridge – Extendicare Nursing Home
Lloydminster – Dr. Cooke Nursing Home
Mayerthorpe – Extendicare Nursing Home
Peace River – Sutherland Nursing Home
Ponoka – Northcott Lodge Nursing Home
Provost and District Nursing Home
Red Deer – Valley Park Manor Nursing Home
Stettler Nursing Home
St. Albert – Youville Nursing Home
Two Hills – Eagleview Nursing Home
Viking – Extendicare Nursing Home
Vulcan – Extendicare Nursing Home
Wetaskiwin Nursing Home

SENIOR CITIZENS' LODGES (84)

Andrew Senior Citizens' Lodge
Athabasca – Pleasant Valley Lodge
Barrhead – Hillcrest Senior Citizens' Lodge
Bashaw – Bashaw Valley Lodge
Bassano – Playfair Lodge
Berwyn – Autumn Lodge
Black Diamond – High Country Lodge
Bonnyville – Bonny Lodge
Bow Island – Pleasant View Lodge
Boyle – Wildrose Villa
Calgary – Beaver Dam Lodge #1200
Calgary – Bow Valley Lodge #100
Calgary – Bow Valley Lodge #200
Calgary – Bow Valley Lodge #300
Calgary – Bow Valley Lodge #1100
Calgary – Confederation Park Lodge
Calgary – Elbow Valley Lodge #700
Calgary – Elbow Valley Lodge #800
Calgary – Jacques Lodge #400
Calgary – Jacques Lodge #500
Calgary – Jacques Lodge #600
Calgary – James Shouldice Lodge #1300
Calgary – Rundle Lodge #900
Calgary – Valleyview Lodge #1400
Camrose – Stoney Creek Lodge
Canmore – Bow River Lodge
Cardston – Chinook Lodge
Coaldale – Sunny South Lodge
Cold Lake Lodge
Drayton Valley – Shangri La Lodge
Drumheller – Sunshine Lodge
Edmonton – Sunshine Lodge

Edmonton – Belvedere Lodge
Edmonton – Bethany Lodge
Edmonton – Beverly Lodge
Edmonton – Elmwood Lodge
Edmonton – Ottewell Lodge
Edmonton – Pleasantview Lodge
Edson – Parkland Lodge
Fort Macleod – Pioneer Lodge
Fort Saskatchewan – Dr. Turner Lodge
Grande Prairie – Heritage Lodge
Grande Prairie – Pioneer Lodge
Hanna Lodge
High Prairie – Pleasant View Lodge
High River – Medicine Tree Manor
Hines Creek – Homesteader Lodge
Holden Lodge
Innisfail – Autumn Glen Lodge
Lamont – Beaverhill Pioneer Lodge
Legal – Chateau Sturgeon Lodge
Lethbridge – Blue Sky Lodge
Lethbridge – Heritage Lodge
Lloydminster – Pioneer Lodge
Magrath – Diamond Willow Terrace Lodge
Manning – Del-Air Lodge
Mayerthorpe – Pleasant View Lodge
Medicine Hat – Cypress View Lodge
Medicine Hat – Teeoda Lodge
Medicine Hat – Wild Rose Lodge
Morinville – Heritage Place Lodge
Mundare – Father Filas Lodge
Myrnam – Eagle View Lodge
Nanton – Silver Willow Lodge
Olds – Mount View Lodge
Oyen Senior Citizens' Lodge
Pincher Creek – Crest View Lodge
Ponoka – Golden Leisure Lodge
Provost – Hillcrest Lodge
Red Deer – Pines Lodge
Red Deer – Twilight Lodge
Redwater – Diamond Spring Lodge
Rimbey – Parkland Manor
Sedgewick – Flagstaff Lodge
Strathmore – Wheatland Lodge
St. Albert – Chateau Mission Court
Sylvan Lake Lodge
Taber – Clearview Lodge
Tofield Lodge
Two Hills – Hillside Senior Citizens' Lodge
Valleyview – Red Willow Lodge
Viking – Vialta Lodge
Vulcan – Peter Dawson Lodge
Warburg – Clover Leaf Manor
Winfield – West Pine Lodge

MENTAL HEALTH (2)

Edmonton – Alberta Hospital
Ponoka – Alberta Hospital

COMPLAINTS

The Committee receives written and telephoned complaints in addition to those received during visits. These complaints take precedence over routine visits and are investigated as soon as possible. Exceptions are concerns of a non-urgent nature which do not affect patient care. These are investigated on the next routine visit to the institution.

The question of investigating anonymous complaints has been debated from time to time, and the Committee has adopted the practice of accepting such complaints when they appear serious enough to warrant investigation. The Committee has chosen this position recognizing that patients and relatives sometimes fear that staff's attitudes towards them may change if they lodge a complaint. This fear may be unfounded, but it is not surprising that people feel vulnerable when they are completely dependent on the service of others.

The Committee received 75 complaints during the year. Seven complaints received late in 1984 were investigated and resolved in 1985.

TYPE of FACILITY	NUMBER of COMPLAINTS
General Hospitals	19
Auxiliary Hospitals	8
Nursing Homes	22
Senior Citizens' Lodges	17
Mental Health Hospitals	3
Miscellaneous	6

STATUS of COMPLAINTS at END of YEAR	
Resolved	34
Recommendations made	17
Outside Committee's jurisdiction	9
Withdrawn by complainant	3
Unsubstantiated	5
Referred to appropriate authority	4
Held over to 1986	3

NATURE OF COMPLAINTS

General Hospitals:

- Alleged wrong medication.
- Poor staff morale.
- Poor patient care.
- Noise and activity.
- Poor management.

Auxiliary Hospitals:

- Poor patient care.
- Food.
- Missing valuables.
- Move to different ward against patient's wishes.
- Overcrowding and poor physical conditions.

Nursing Homes:

- Food.
- Noise.
- Understaffing.
- Family difficulties with administration.
- Poor staff attitudes.
- Poor patient care.
- Fire safety standards.
- Use of restraints.
- Objections to paying monthly fee for cable television.

Senior Citizens' Lodges:

- Lack of planned activities.
- Refusal to admit person as resident.
- Unfairness in allocating rooms.
- Poor resident morale.
- Non-segregation of smokers.
- Food.
- Residents not informed about use of money from bazaars.
- Staff objecting to distributing medications.
- Poor management.
- High staff turnover.
- Poor staff morale.
- Notice of eviction.

Mental Health Hospitals:

- Relative wished to have patient moved to a nursing home.
- Alleged missing possessions.
- Overcharging.

Miscellaneous:

- Physiotherapy services.
- Doctor's refusal to give X-rays to patient.
- Placement practices.
- Hiring practices.

APPENDIX III

PROVINCE OF ALBERTA

HEALTH FACILITIES REVIEW COMMITTEE ACT

CHAPTER H-4
REVISED STATUTES OF ALBERTA 1980

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HEALTH FACILITIES REVIEW COMMITTEE ACT

CHAPTER H-4

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "Committee" means the Alberta Health Facilities Review Committee and includes a subcommittee established under section 3;

(b) "hospital" means

(i) an approved hospital under the *Hospitals Act*,

(ii) any other hospital, institution or other facility for the treatment and care of persons that is owned and operated by the Government of Alberta, except those operated under the administration of the Minister of Social Services and Community Health or those that receive their current operating funds or part of them from a supply vote that is under the administration of a member of the Executive Council other than the Minister of Hospitals and Medical Care,

(iii) a contract nursing home as defined in the *Nursing Homes Act*, or

(iv) a home or unit operated under the *Senior Citizens Housing Act;*

(c) "Minister" means the Minister of Hospitals and Medical Care;

(d) "patient", with reference to a home or unit operated under the *Senior Citizens Housing Act*, means a person who resides in that home or unit.

1972 c49 s1;1973 c29 s2(2),(3);1974 c69 s3(2);1975(2); c21 ss1,4(a); 1977 c62 s12(1);1978 c73 s17;1978 c62 s3;1980 c22 s2;1980 c46 s18

Committee established

2(1) There is hereby established a committee called the "Alberta Health Facilities Review Committee" consisting of not more than 12 members appointed by the Lieutenant Governor in Council.

(2) The members of the Committee may include members of the Legislative Assembly who are not members of the Executive Council.

(3) An order appointing a member of the Committee may provide for his term of office but in the absence of such a provision, the term of office of a member is one year from the effective date of his appointment and thereafter until his successor is appointed.

(4) The Lieutenant Governor in Council shall designate one of the members of the Committee as chairman and another as a vice-chairman and, unless the order otherwise provides, the term of office of a chairman or vice-chairman so designated is one year from the effective date of the designation and until their respective successors are thereafter designated.

(5) The vice-chairman is the acting chairman of the Committee in the event of the absence or inability to act of the chairman or a vacancy in the office of chairman.

1972 c49 s2;1978 c62 s3

Sub-committees

3(1) The Committee may

(a) establish one or more sub-committees to perform those duties and functions and exercise those powers of the Committee prescribed by the Committee, and

(b) appoint as members of a sub-committee not less than 3 members of the Committee.

(2) When a sub-committee is established, the Committee shall designate a member of a sub-committee to preside over the sub-committee.

(3) A member of the Committee may be appointed to more than one sub-committee.

(4) A majority of the members appointed to a sub-committee constitute a quorum of the sub-committee.

(5) A decision or other action made or taken by a sub-committee at which its quorum is present is the decision or action of the Committee and binds all members of the Committee.

(6) Two or more sub-committees may act simultaneously.

(7) If a sub-committee is performing a duty or function or exercising its powers and one or more members of the sub-committee are absent during a portion of the time that the sub-committee is performing a duty or function or exercising a power, the remaining members of the sub-committee that are present may, if they constitute a quorum of the sub-committee, perform the duty or function and exercise the power of the sub-committee.

(8) Notwithstanding that a sub-committee is established under this

section, the Committee may also perform any duty or function or exercise any power that it prescribed the sub-committee to perform or exercise.

1980 c22 s3

Remuneration and expenses

4 The Lieutenant Governor in Council

(a) may prescribe the rates of remuneration payable to members of the Committee other than those who are employees of the Government or members or employees of an agency of the Government, and

(b) may authorize the payment of travelling and living expenses for members of the Committee while outside their normal place of residence in the course of performing their duties.

1972 c49 s3;1979 c18 s6

Staff

5(1) The Minister may appoint an employee of the Government under his administration as the Executive Director of the Committee who shall under the direction of the chairman of the Committee assist the Committee in carrying out its duties and functions and exercising its powers.

(2) The Minister shall provide to the Committee the services of employees of the Government under his administration and supplies for the purpose of carrying out secretarial, clerical and related work that the Committee may reasonably require to enable it to carry out its duties and functions and exercise its powers.

1972 c49 s4;1975(2) c21 s4(b);1977 c62 s12(1);1980 c22 s4

Meetings

6 The Committee may, with the approval of the Lieutenant Governor in Council, make rules governing the calling of its meetings, the quorum required at its meetings, the procedure at its meetings, and any other matter relating to the conduct of its business and affairs.

1972 c49 s5

Visiting hospital

7(1) The Committee shall from time to time visit all hospitals for the purpose of reviewing and inspecting them and the manner in which they are operated.

(2) The Minister may from time to time request the Committee to conduct a visit to a hospital for the purposes of reporting to the Minister on any matter that the Minister specifies in his request.

1972 c49 s6(1),(4);1980 c22 s5

Investigation of hospital

8 If a complaint is made to the Committee by or on behalf of a patient in a hospital, the Committee shall investigate the care and treatment and the standards of accommodation received by that patient or any other patient in the hospital.

1978 c62 s4;1980 c22 s5

Entry of hospital

9 For the purpose of carrying out a visit or an investigation under

this Act the Committee may enter a hospital at any reasonable hour.

1980 c22 s5

Inspection of hospital records

10(1) The Committee, with respect to a visit or an investigation under this Act, is entitled to access to the records of the hospital for the purpose of inspecting them, making copies of them or taking extracts from them.

(2) Subsection (1) does not apply to

(a) the financial records of the hospital that relate to the operation of the hospital, or

(b) the medical and clinical records of a patient unless the patient or his guardian gives his consent to those records being inspected.

1972 c49 s7;1980 c22 s5

Exemption

11 Nothing in this Act shall be construed as empowering the Committee or other person acting under this Act to inquire into the financial affairs of the hospital that relate to the operation of the hospital.

1972 c49 s6(6);1980 c22 s5

Persons acting on behalf of Committee

12(1) The Committee may authorize

(a) a member of the Committee to carry out a visit or investigation on behalf of the Committee, or

(b) subject to the approval of the Minister, an employee of the Government under the Minister's administration to carry out a specific inquiry on behalf of the Committee in respect of a visit or investigation.

(2) When a member of the Committee or other person has carried out a visit, investigation or specific inquiry on behalf of the Committee, that member or person shall report his findings to the Committee.

1972 c49 s6(5);1980 c22 s5

Complaint officer

13(1) The Committee may designate

(a) a member of the Committee, or

(b) with the approval of the Minister, an employee of the Government who is under the administration of the Minister,

as a complaint officer.

(2) The complaint officer shall on behalf of the Committee

(a) make preliminary inquiries, or

(b) if directed to do so by the chairman of the Committee, make investigations

into complaints received under section 8 and report the results of the inquiry or investigation to the Committee.

(3) Members of the Committee at the request of the chairman of the Committee may assist the complaint officer in the carrying out of his duties.

1980 c22 s5

Powers of Committee members

14 A member of the Committee or an employee of the Government carrying out a visit, investigation or other matter on behalf of the Committee has the same powers that the Committee would have if it were carrying out the visit, investigation or other matter.

1972 c49 s6(3);1980 c22 s5

Court order

15(1) If the Committee, a member of the Committee or an employee of the Government acting on behalf of the Committee is refused entry to a hospital for the purposes of conducting a visit or an investigation, the chairman of the Committee or a person designated by him may apply to the Court of Queen's Bench by originating notice for an order permitting the Committee, member or employee to

(a) enter the hospital at any reasonable hour and conduct the visit or investigation, and

(b) require the production of any records of the hospital, other than those referred to in section 10(2).

(2) An application under subsection (1) may be made ex parte, if the Court considers it proper to do so in the circumstances.

1980 c22 s5

Annual report

16(1) As soon as possible after the end of each year, the Committee shall prepare and submit to the Minister a report summarizing its activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then in session, and if not, within 15 days after the commencement of the next ensuing session.

1972 c49 s8

Act binds Crown

17 This Act binds the Crown.

1980 c22 s6

HEALTH FACILITIES REVIEW COMMITTEE

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